BOILERMAKERS LODGE NO. 191 BENEFIT PLAN

Address all inquiries to:

The Plan Administration Office
45 McIntosh Drive
Markham, ON L3R 8C7
Phone: 1-800-263-3564
Fax: 905-946-9700
Email: questions@boilermakers191benefits.ca

www.boilermakers191benefits.org

As of June 1, 2025

PRIVACY POLICY

We, the Trustees of The Boilermakers Lodge No. 191 Benefit Plan have adopted the following *Privacy Principles,* which reflect our commitment to safeguarding our Members' personal information:

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek a correction of your personal information if you believe that the information held by the Plan is not accurate.
- You may access your personal information, subject to limited exceptions and conditions.
- Personal information is not disclosed without Member's permission except in limited circumstances as permitted or required by law. However, the Administrator may share personal information with the Plan's actuaries, agents, consultants or service providers in connection with providing, administering, adjudicating, costing, financially managing and servicing Members' Plans and benefit programs.
- Where we choose to have certain services, such as actuarial valuation, provided by third parties, we take all reasonable precautions regarding the practices employed by the service provider to protect your personal information. We ask that they, in turn, undertake to honour the Plan's privacy policy and applicable legislation.
- To protect your personal information against unauthorized access, disclosure, copying, use or modification, theft or accidental loss, the Plan will maintain appropriate security mechanisms.

The Trustees

The following is an outline of The Boilermakers Lodge No. 191 Benefit Plan benefits. The information in this benefit booklet is important to you. It provides the information you need about the group benefits available through The Boilermakers Lodge No. 191 Benefit Plan.

Both British Columbia and Alberta have passed legislation affecting the use of self-insured funding for providing benefit plans. In each case, the legislation allows for the use of self-insured funding, subject to disclosing this information to the covered Members in writing.

The Trustees are constantly attempting to provide benefits under the Plan to the Members in the most cost-effective manner. For some benefits, such as Dental, Weekly Indemnity and some portions of the Extended Health Benefits, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided through the Plan are not insured by an insurance company regulated under the Financial Institutions Act, and the Plan is exempt from the regulatory requirements of the Act.

SCHEDULE OF BENEFITS

Medical Plan (Medical Services Plan of British Columbia – Group No. 3131919)	As provided by MSP
Life Insurance	$60,000
Accidental Death & Dismemberment	$60,000
Spousal Life Insurance	$25,000
Weekly Indemnity Benefit	EI Maximum (integrated with EI)
Dental Plan	100% Basic, 75% Major – unlimited 50% Orthodontic to a maximum of $2,000 per lifetime
Extended Health Benefits	100% eligible expenses, no deductible, maximum $1,000,000 per policy period
Out of Province/Canada Emergency Medical Travel Insurance	$5 Million maximum per coverage period
Vision Care (Eye glasses/contacts)	100% to a maximum of $750 every 24 months (12 months for dependent children under age 19)
Employee & Family Assistance Program	See this section of the booklet for details

ELIGIBILITY DETAILS

Who is eligible?
Any Member in good standing who has sufficient hours for coverage and is working under a collective agreement requiring employer contributions to this Plan.

Do any Forms have to be completed?
YES. You must complete a Medical Services Plan application form and an Enrolment and Beneficiary card.

How does a person qualify for coverage?
Permit Members or Lodge 191 Members who have been suspended or have taken a withdrawal card, must become Members in good standing of Lodge 191. Coverage under the Plan will commence on the 1st day of the month following the month (lag) in which 350 hours have been credited to the Member's hourbank.

In order for Travel Card Members to qualify for coverage, they must become a Member in good standing of Lodge 191, at which time, reciprocation to their previous union plan will stop and the accumulation of 350 new hours to the Plan would begin accumulating. Coverage under the Plan would commence on the 1st day of the month following the month (lag) in which 350 hours have been credited to the Member's hourbank as a Lodge 191 Member in good standing. There is no accumulation of hours prior to Travel Card Members transferring to Lodge 191.

EXAMPLE:
Your employer(s) report your hours on a monthly basis. In the example below, it is on the November report when you reach the 350 hour level. November hours are reported in December (the lag month) and coverage becomes effective on the 1st day of January.

Month	**Hours Reported**
September	75 hours
October	100 hours
November	200 hours
December	(Lag Month)
January	Coverage Starts

Each month 125 hours will be deducted from the hourbank to provide coverage. Any excess hours will accumulate in your hourbank for future coverage.

Once coverage starts, you will continue to be covered as long as your hourbank contains sufficient hours.

A maximum of 8 months' coverage can be accumulated in a Member's hourbank.

When does coverage end?

a) Coverage will terminate when there are insufficient hours in the hourbank to allow for a deduction of 125 hours.

b) Coverage will be terminated immediately and the hourbank will be forfeited for any Member who is suspended or issued a withdrawal card.

c) Coverage will terminate once the Member has reached their maximum number of self-payments allowed by the Plan, or a self-payment notice sent to the Member is not returned with payment.

Self-Pay:

A Member in good standing of Lodge 191 (dues paying) may continue full coverage through self-payment. A self-pay notice will be sent to the last known address. The maximum number of self-pays allowable is 12 consecutive months.

Members in good standing, who have registered for retired members cards through the Union, on or after January 1, 2021, who are covered by the Plan on the date they retire, will be permitted to continue to be covered by the Plan until the hours in their hourbank are exhausted, at which point, they will be given the opportunity to continue their coverage by self-paying for a further 24 consecutive months (effective January 1, 2024 - previously 12 consecutive months). If such retired Member returns to work for a signatory employer, those hours reported and paid to the Plan on behalf of that Member will be permitted to accumulate in their hourbank until sufficient hours permit requalification of coverage under the Plan. PLEASE NOTE: benefits provided under the Plan coverage are subject to the maximum age permitted by each benefit. The maximum age for Life Insurance, AD&D and Emergency Medical Insurance and Travel Assistance is upon attaining age 80.

Reminder: If full coverage lapses for a Member who has continually been a Member in good standing, then that Member will be required to accumulate 250 new hours reported to the Plan in order to re-qualify for full benefits.

Disability Credits:

For disabilities incurred on or after January 1, 2024, when a Member is collecting benefits under the Weekly Indemnity Plan, EI Sick Benefits or under WorkSafe BC, Members can apply to the Plan Administrator to receive assistance with their hourbank. Once approved for Disability Credits, the Member's hourbank balance will be 'frozen', and for each day that the Member is disabled and on a claim that has been accepted for payment, the Member's hourbank will be credited with contributions of 8 hours per day, subject to a maximum of 125 hours per month for up to 12 months. The

Member must request the appropriate form from the Administration Office and return the completed form to apply for Disability Credits.

To qualify for these Disability Credits, the Member must be eligible for benefits when the disability commences. If the Member is disabled for longer than the maximum Weekly Indemnity claim of 26 weeks, the Member must contact the Administration Office to inquire about further disability credits. Evidence of continued disability must be provided.

If the Member remains disabled after receiving 12 consecutive months of Disability Credits, coverage will continue if there are sufficient hours in their hourbank to allow for a deduction of 125 hours, or if they opt to self-pay for their coverage up to the maximum of 12 consecutive months permitted.

PLEASE NOTE: During the months that a Member is self-paying for coverage, the pay-direct card will not be activated/re-activated until payment is received by the Administrator and processed. If a prescription or other eligible benefit that would normally be claimed using the pay-direct card, is required prior to that, the Member or dependent will be required to pay for the expense and submit the claim to the Administrator for reimbursement.

Can hours be suspended while working for another Lodge 191 employer who does not contribute to this Plan?
YES. On notification from the Union office, hours can be "frozen" while you are covered with another employer under Lodge 191's jurisdiction, who does not contribute to this Plan. Hours can be frozen up to 12 months, at which time they will be forfeited.

Are there any reciprocity agreements with other Boilermaker Locals?
YES. If a Member is working under another local of the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers, they may be entitled to have their contributions remitted to The Boilermakers Lodge 191 Benefit Plan. The Union office must be contacted to ensure there is a reciprocity agreement in place with the local you are working in and you must advise the local in which you are working that you are a Member of Lodge 191 and wish your contributions transferred to this Plan.

Are Dependents Covered under the Plan?
YES. The Plan will provide MSP, Dental, Extended Health Benefits and Vision Care for:

a) The spouse* of a covered Member;

b) Any unmarried child of a covered Member to age 21, (age 19 for MSP) provided such person is mainly dependent on and living with the covered Member;

c) Any unmarried child of a covered Member to any age provided the child is in full-time attendance at a recognized school, college, or university; (age 25 for MSP)

d) Any unmarried mentally or physically handicapped child of a covered Member to any age, provided such person is mainly dependent on and living with the covered Member or the spouse of the covered Member.

*Spouse means the Member's legal spouse, or a person who has been residing with the Member continuously for a period of at least one year and has been publicly represented as the Member's spouse in the community in which they reside.

When completing your application forms for coverage, please include all dependents to be covered. To add, delete or change the dependents covered, obtain a MSP Group Change Form and an Enrolment and Beneficiary card from the Administrator or your Union Office, and forward it to the Administrator's office.

Survivor Benefits

When a covered Member becomes deceased, if there is a balance in their hourbank sufficient to provide coverage, the surviving eligible dependents may continue to be covered under the Plan until there are insufficient hours in the hourbank to allow for a deduction of 125 hours. At that point, the surviving eligible dependents will be provided the option to self-pay their coverage for up to 12 additional months. If the Member is self-paying for coverage during the month of their death, the surviving eligible dependents will be permitted to continue to self-pay for up to a maximum of 12 months, inclusive of the months which were already self-paid up to and including the month of death of the Member.

MEDICAL SERVICES PLAN OF BC (MSP)

When you qualify for coverage, you will be covered by the Medical Services Plan of B.C., provided you have completed the required MSP application form. If you do not apply for MSP coverage through the Plan at the time you become eligible to do so, the Plan will only make retroactive payments on your behalf back 3 months for MSP coverage.

LIFE INSURANCE

Each eligible Member is insured for Life Insurance as specified on Page 1. The maximum age for Life Insurance coverage is attaining age 80.

This amount of insurance is payable to the beneficiary designated by you should your death occur from any cause while you are insured under the group policy.

If you do not designate a beneficiary, the insurance will be payable to your estate.

SPOUSAL LIFE INSURANCE

If your spouse should die while insured for this benefit, the $25,000 Spousal Life Insurance will be paid to you, if living, otherwise to your estate.

Continuation of Life Insurance on Termination of Coverage
When your coverage with the Plan terminates, you may convert your Life Insurance to an individual policy without a medical examination or health questionnaire. The individual policy would be for an amount not greater than the amount under the group policy and would be available at any time within 31 days after termination of the group insurance. Contact the Administrator for details.

Your life would be continued to be insured under the group policy during the 31 day conversion period, whether or not you apply for an individual policy.

If you Become Totally Disabled
Subject to satisfactory proof, submitted within 12 months from the date the Member becomes totally disabled, a Member who is under age 65 and who becomes totally disabled and continues to be disabled for 6 months, as a result of accident, injury or disease will, on written application, be eligible for the total amount of the Life Insurance to remain in force providing the person remains totally disabled, subject to termination at age 65. Proof of total disability will be required from time to time.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the Schedule of Losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is covered?	**Amount of Coverage**
All eligible Members	$60,000
All spouses under age 70	$20,000
All eligible dependent children	$ 5,000

Schedule of Losses

Loss of Life.....The Principal Sum
Loss of Both Hands .....The Principal Sum
Loss of Both Feet.....The Principal Sum
Loss of Entire Sight of Both Eyes.....The Principal Sum
Loss of One Hand and One Foot.....The Principal Sum
Loss of One Hand and the Entire Sight of One Eye
.....The Principal Sum
Loss of One Foot and the Entire Sight of One Eye
.....The Principal Sum
Loss of One Arm.....Four-Fifths of The Principal Sum
Loss of One Leg .....Four-Fifths of The Principal Sum
Loss of One Hand .....Three-Quarters of The Principal Sum
Loss of One Foot .....Three-Quarters of The Principal Sum
Loss of The Entire Sight of One Eye
.....Three-Quarters of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand
.....One-Third of The Principal Sum
Loss of Speech or Hearing . .Three-Quarters of The Principal Sum
Loss of Speech and Hearing .....The Principal Sum
Loss of Hearing in One Ear.....Two-Thirds of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs) ....
.....Two Times The Principal Sum
Paraplegia (total paralysis of both lower limbs) .....
.....Two Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of
one side of the body).....Two Times The Principal Sum
Loss of Use of Both Arms or Both Hands.....The Principal Sum
Loss of Use of One Hand or One Foot .....
.....Three-Quarters of The Principal Sum
Loss of Use of One Arm or One Leg .....
.....Four-Fifths of The Principal Sum
Loss of Four Fingers of One Hand .....
.....One-Third of The Principal Sum
Loss of All Toes of One Foot .....
.....One-Quarter of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; as used with reference to fingers means complete severance through or above the first phalange of all four fingers of one hand; as used with reference to toes means complete severance of both

phalanges of all the toes of one foot and as used with reference to eye means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye.

Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing;

Loss of Hearing in One (1) Ear means the diagnosis of permanent Loss of Hearing in one (1) ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels an ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing;

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds.

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the Administrator, "the Plan" and a licensed practicing physician appointed by Blue Cross Life "the Company", or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Disappearance

If the body of an Insured Member has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Member shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Member under the Policyholder's current basic Group Life Insurance Policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Member.

All other benefits shall be payable to the Insured Member.

Repatriation Benefit
When Injuries covered by this policy result in loss of life of an Insured Member outside 50 Km from their permanent city of residence and within 365 days of the date of the accident, the Company shall pay the actual expenses incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased but not to exceed the amount of $15,000.00.

Rehabilitation Benefit
If an Insured Member suffers an Injury which results in a payment being made by the Company under the Accidental Death and Dismemberment Indemnity section of this policy, the Company shall pay in addition:

The reasonable and necessary expenses actually incurred up to a limit of $15,000.00 for special training of the Insured Member provided:

a) Such training is required because of such Injuries and in order for the Insured Member to be qualified to engage in an occupation in which they would not have been engaged except for such Injuries,

b) Expenses be incurred within three years from the date of the accident,

c) No payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation
When Injuries covered by the policy result in an Insured Member being confined to a hospital, outside 100 Km from their permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.00.

Conversion Privilege
On the date of termination of coverage or during the 90-day period following termination of coverage, you may change your insurance to Blue Cross Life's individual insurance policy. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the plan ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage
In the case of Members who are (1) laid-off on a temporary basis (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of twelve (12) months, subject to payment of premium. If a Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium
In the event an Insured Member becomes totally and permanently disabled and their waiver of premium claim is accepted and approved under the Plan's current group life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

a) The date the Insured Member attains age 65.

b) The date of the death or recovery of the Insured Member.

c) The date the Insured Member is no longer eligible for total disability waiver of premium under the Policy-holder's group life policy; and

d) The date the Master Policy is terminated.

Seat Belt Rider
Benefits under the policy shall be increased by 10% if the Insured Member's Injury or death results while they are a passenger or driver of a private passenger type automobile and their seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Home Alteration and Vehicle Modification
If an Insured Member receives a payment under The Schedule of Losses herein and was subsequently required (due to the cause for which payment under The Schedule of Losses was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

a) The one-time cost of alterations to the Insured Member's residence to make it wheel-chair accessible and habitable.

b) the lesser of:

   i) the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured Member, to make the vehicle accessible or drivable for the Insured Member; and

   ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

Benefit payments herein will not be paid unless:

i) Home alterations are made on behalf of the Insured Member and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and

ii) Vehicle modifications are made on behalf of the Insured Member and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items (a) and (b) combined will not exceed $15,000.00.

Dependent Child Educational Benefit
If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Member up to the lesser of the following amounts:

a) ten thousand dollars ($10,000.00) per school year; or

b) 5% of such Insured Member's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

a) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12th) grade level; and

b) only while such Dependent Child continues their continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who has incurred the actual tuition expenses.

Spousal Educational Benefit
If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Member's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independents source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Member's Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars ($15,000.00) per Insured Member.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was

dependent upon the Insured Member for at least 50% of their maintenance and support.

"Institution of Higher Learning" as used herein includes, but is not limited to, any university, private post secondary college or trade school, and any College of General and Vocational Education/Collège d'enseignement général et professionnel (CÉGEP).

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

a) the actual annual cost charged by a commercial and licenced day care centre; or

b) 5% of the Insured Member's Principal Sum; or

c) five thousand dollars ($5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

a) and only for such Dependent Child who at the date of the Insured Member's Loss of Life is under age thirteen (13);

b) provided such Dependent Child is enrolled in a commercial and licenced day care centre no later than ninety (90) days following the Insured Member's Loss of Life; and

c) provided that the Dependent Child continues their enrollment in a commercial and licenced day care centre.

In-Hospital Benefit

If an Insured Member suffers Injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Member is, pursuant to the instructions of a Physician, confined to a Hospital for more than five (5) consecutive overnight stays, the Company will pay:

a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Member's Principal Sum; or

b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined for each overnight stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital.

The maximum amount payable for this benefit for all Injuries resulting from any one (1) accident per Insured

Member is two thousand five hundred dollars ($2,500.00) per month.

Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

The term **"Hospital"** is defined as an establishment which meets all of the following requirements:

1) holds a license as a hospital (if licensing is required in the province);
2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
3) provides 24-hour a day nursing service by registered or graduate nurses;
4) has a staff of one or more licensed physicians available at all times;
5) provides organized facilities for diagnosis, and major medical surgical facilities; and
6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

If an Insured Member suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Member less any amounts under the Table of Losses which have been paid or which are payable by the Company for Losses of the Insured Member.

Exclusions

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

a) suicide or any attempt thereat by the Insured Member while sane;
b) self inflicted Injury or any attempt thereat by the Insured Member while sane or insane:
c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:

   i) riding as a passenger in any aircraft not intended or licenced for the transportation of passengers; or

   ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

   iii) riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accident cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained while the Insured Member is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;

m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit

any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

n) an act, attempted act or omission taken or made by the insured Member, or an act, attempted act or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

o) natural causes.

WEEKLY INDEMNITY BENEFIT

A benefit of the Employment Insurance (EI) weekly maximum benefit rate will be paid to each eligible Member who is disabled and unable to work as the result of a non-occupational accident or sickness. Benefit payment commences on the 1st day of a non-occupational accident, and the 4th day of a non-occupational sickness. If you are hospitalized prior to the 4th day of sickness, benefits commence on the 1st day of hospitalization. If a surgical procedure is performed on an out-patient basis, in a general hospital, benefits will commence on the date the surgery was performed.

Note: A Member who makes a claim for Weekly Indemnity benefits must be seen and treated by a physician within 3 days (excluding weekends) of disability, unless there are extenuating circumstances. Otherwise, the determination of eligibility for benefit commencement date will be as of the first day of treatment.

Members whose disabilities originate during the reporting period (lag month) will be considered disabled from the date on which the Plan Member qualifies for full coverage under The Boilermakers Lodge No. 191 Benefit Plan.

If you are eligible for EI sick benefits, benefits from the Plan will cease during the period you are eligible to collect EI. If you are still disabled after reaching the maximum duration of EI sick benefit payments, or if you are not eligible for EI, or only partially eligible, the Plan will continue benefits for up to a maximum of 26 weeks including the EI sick benefit payments.

How to claim for Weekly Indemnity:
Take the following steps as soon as possible after you have become disabled:

a) Contact your doctor immediately upon becoming disabled. **You must be seen and treated during the time of your disability.**

b) Obtain a claim form from the Union office or the Administrator's office and note instructions concerning an EI sick claim.

c) Complete the form where indicated and have your doctor complete the physician's portion of the form.

d) Your Union must complete the Authorization at the bottom of the form.

e) Send the completed form to the Administrator without delay.

f) Claim cheques will be sent directly to your home address.

g) Claims for disability must be submitted no later than 30 days after your total disability begins.

Third Party Liability
Where a Member becomes Totally Disabled as a result of an injury or sickness in respect of which

a) a third party may be, directly or indirectly, either in whole or in part, liable to the Member or

b) the Member has a claim for benefits under workers compensation legislation;

the Plan will not pay benefits to the Member.

Recurrence of Former Ailments
You will not receive benefits for more than 34 weeks as a result of disability due to any one ailment. However, a new waiting period and benefit duration period will start if you return to active full-time work for:

a) A period of 2 weeks before you again become disabled because of the same or related cause, or

b) One full day before you again become disabled because of a different or unrelated cause.

EXCLUSIONS and LIMITATIONS:
No benefit will be paid for periods of disability:

- arising from a motor vehicle accident.
- arising from an occupational accident or illness, as these are covered by WorkSafe BC/workers compensation legislation; except as a fully repayable loan upon receipt of a signed Loan & Replacement Agreement between the Member and the Plan.
- arising from self-inflicted injuries or disease with the exception of alcoholism and drug addiction. A person is not considered totally disabled due to the use of drugs or alcohol unless the person is being actively supervised by and receiving continuous treatment for that disability from a rehabilitation centre, a physician or an institution provincially designated for that treatment.

- arising from injuries or disease resulting from war or participation in a riot, arising while serving as a member of any armed service.
- arising from pregnancy related illness during a period for which the individual (a) is entitled to receive benefits from EI, or (b) is entitled to pregnancy leave of absence by reason of provincial or federal statute, or any greater period of leave as granted by the individual's employer by way of contract or agreement, verbal or written, or is not entitled to pregnancy leave of absence.
- during which the insured is receiving or eligible to receive EI benefits.
- any day you perform any form of work for wage or profit.
- arising from your commission of or attempt to commit an assault or criminal offense.
- if you become disabled during a strike or lockout at your place of employment, your rights to benefits will be reinstated when the strike or lockout ends.

TERMINATION OF BENEFIT

Your benefit payments will cease on the earliest date one or more of the following occurs:

- you are no longer disabled;
- your are no longer receiving continuing medical care or treatment from your physician;
- you fail to submit satisfactory proof of continuing disability as required by the Plan;
- you refuse a medical examination by a physician chosen by the Plan;
- you are no longer following the treatment recommended for your disability;
- you leave the province, state or country where you normally work and live, for reasons other than to obtain treatment that is not available locally or that may be available sooner elsewhere. Such treatment must be recognized by the government plan (i.e. the Medical Services Plan of British Columbia and similar programs in other parts of Canada) as medically necessary. If you normally reside outside Canada, such treatment must be approved by the Plan.
- you perform any work for compensation or profit;
- the end of the maximum benefit period indicated in the Schedule of Benefits;
- you retire; or
- you die.

DENTAL PLAN

The Dental Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you. The Plan provides pay-direct claims processing using your pay-direct card – present your pay-direct card at your dentist's office.

Part I – Basic Services

The following services are eligible for reimbursement of the lesser of 100% of the amount charged or 100% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment.

1) Diagnostic Services
   All necessary procedures to assist the dentist in evaluating the existing conditions to determine the required dental treatment, including:
   - Oral examinations: limited to two in any calendar year; however, complete oral examinations are limited to one in any 36 month period.
   - Dental x-rays: bite-wing x-rays are limited to one set in any 6 month period, full mouth x-rays are limited to one set in any 36 month period, and panoramic film is limited to one x-ray in any 36 month period.

2) Preventative Services
   All necessary procedures to prevent the occurrence of oral disease, including:
   - Cleaning (limited to twice in any calendar year)
   - Scaling and root planing (combined maximum of 15 units per calendar year)
   - Topical application of fluoride (limited to two applications in any calendar year)
   - Pit and fissure adhesive sealants limited to once per tooth every 24 months for children under 18
   - Fixed space maintainers on primary teeth for dependent children under 18
   - Oral hygiene instruction allowed once in any 36 month period.

3) Surgical Services
   All necessary procedures for extractions and other routine oral surgical procedures normally preformed by a dentist.

4) Restorative Services
   All necessary procedures for:
   - Filling teeth with amalgam, silicate, acrylic or composite restorations

- Replacement restorations if at least 12 months has elapsed since initial placement.
- Stainless steel crowns on primary teeth.

5) Prosthetic Repairs and Maintenance
Repair if a 6-month period has elapsed since the last date on which the dentures were provided.

Denture maintenance, after the 3 month post insertion care period, including:

- denture relines for dentures at least 6 months old, once every 36 months
- denture rebases for dentures at least 2 years old, once every 36 months
- resilient liner in relined or rebased dentures, once every 36 months.

6) Endodontia (Root Canals)
All necessary procedures required for pulpal therapy and root canal filling. Repeat treatment is covered only if the original treatment fails after the first 18 months.

7) Periodontia
All necessary procedures for the treatment of tissues supporting the teeth including grafts.

8) Major Restorative Services
- Inlays, onlays and gold foils will be covered only when other material cannot be used satisfactorily. Patients choosing gold where other materials would suffice will be responsible for the cost difference. A pre-authorization is suggested.

9) Anesthesia
General anesthesia required in relation to oral surgery.

Part II – Major Services
Prosthetic Appliances, Veneers, Crowns and Bridge Procedures

The following services are eligible for reimbursement of the lesser of 75% of the amount charged, or 75% of the Dental Association Fee Guide (General Practitioner) in the Province of treatment:

- Initial installations of full or partial dentures, or fixed bridgework, if required to replace one or more natural teeth that have been extracted. Partials may only be provided by a dentist.
- Initial placement of a crown or veneers and their replacement if at least 5 years has lapsed.
- Replacement of an existing full or partial denture, or fixed

bridgework, if the existing denture or fixed bridgework was installed 5 years prior to its replacement and cannot be made serviceable. Dentures misplaced, lost or stolen will not be replaced at the Plan's expense.

Charges made by a licensed Denturist will be recognized for payment, in accordance with a separate Schedule of Allowances.

Part III – Orthodontia (dependent children under 21 and adults)

For orthodontia services performed by an orthodontist payment will be made at 50% to a maximum lifetime limit of $2,000. Payment of claims will be paid on the basis of eligibility and work completed. Appliances lost, broken or stolen will not be replaced at the Plan's expense.

Pre-Treatment Estimate of Major Restorative & Orthodontic Charges

Prior to the commencement of treatment, the dentist should provide a summary of charges for the proposed course of dental care. The Plan will then provide a written estimate of the maximum amount for which payment will be made.

Alternative Services:

If alternative services may be performed for the treatment of a dental condition, the maximum amount shown in the Suggested Fee Guide for the least expensive service or supply required to produce a professionally adequate result.

Emergency Dental Care Anywhere in the World

In an EMERGENCY, while you are travelling or on vacation outside of your Province of residence, you are entitled to the services of a duly qualified dentist and will be reimbursed at the lower of the actual cost or the amount that would have been paid had the service been rendered in Province of residence.

EXCLUSIONS and LIMITATIONS

The Plan's Dental benefits do not cover payment for:

- items not listed in the Fee Schedule and fees in excess of those listed in the Fee Schedule;
- charges for broken appointments or nutritional instruction, completion of forms, written reports, communication costs or charges for translating documents;
- dental care which is cosmetic;
- dental care provided under a medical plan provided by an employer or government.
- which, in the absence of coverage, there would be no charge;

- stainless steel crowns on permanent teeth;
- protective athletic appliances;
- anesthesia not done in conjunction with surgery, and charges for facilities, equipment and supplies;
- a full mouth reconstruction, for a vertical dimension correction, or for diagnosis or correction of a temporomandibular joint dysfunction;
- replacement of a lost or stolen prosthesis;
- incomplete and temporary procedures;
- implants;
- any dental charge for services which were started prior to the date of coverage; or
- dental treatment which was ordered while covered, (which included lab work and impressions), but was not installed or delivered until more than 31 days after the dental benefit terminated.

Expenses recoverable under any other Plan will be co-ordinated with payments from this Plan, so that total payment received will not exceed the expenses actually incurred.

What is the maximum amount that will be paid for any one person?
There is no limit for Part I and II coverage. The maximum amount that will be paid for Part III (Orthodontia) is $2,000 per lifetime per covered Member or dependent.

EXTENDED HEALTH BENEFITS

There is no annual deductible and 100% of eligible expenses will be reimbursed up to a maximum of $1,000,000 per benefit period. Out of Province/Canada Emergency Medical Travel Insurance coverage is provided to eligible Members and their dependents up to a maximum of $5,000,000 per coverage period.

The Extended Health Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Benefits:
The Extended Health Benefit is designed to help you pay for specified services and supplies incurred by you and your Dependents, when not provided under a government health plan or by a tax supported agency.

The following are classed as eligible expenses when incurred as the result of necessary treatment of illness or

injury and where applicable when ordered by a physician. Upon qualifying for coverage, you will receive a pay-direct card (one if you have single coverage or 2 cards if you have dependent coverage – both cards will be in your name).

1) Prescription Drugs – present your pay-direct card, along with your prescription, to your pharmacist and your prescription drug claim will be adjudicated right at the pharmacy. Using your pay-direct card eliminates the need to send in your prescription receipt and wait for reimbursement. Your Plan provides coverage for prescription drugs and medicines (including oral contraceptives) which require, and can only be obtained, with the written prescription of a licensed physician or dentist if provincial law permits. Drugs and medicines are limited to a 100 day supply. Refills are not permitted to be dispensed earlier than what is deemed to be reasonable and customary. Vacation supplies of your medications, which are outside the regular days supply limits must be pre-authorized by the Plan and must be paid for in full by the Member and submitted to the Plan for reimbursement. Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued. Fertility drugs, vitamins, preventative drugs, dietary foods and supplements are also excluded. Smoking cessation products will be covered up to a lifetime maximum of $500 per person.

   There are a number of prescription drugs which are not eligible under PharmaCare's standard drug formulary, but may be eligible under their Special Authority Program. You may be requested by the Plan to have your doctor apply for Special Authority for one or more of the drugs you have been prescribed. Should PharmaCare approve the application for Special Authority, such drugs will be applied towards your annual PharmaCare deductible.

   PLEASE NOTE: It is mandatory for all Members, who are BC residents, to register for the provincial Fair PharmaCare program and provide proof of such registration to the Administrator in order to continue to receive benefits under the Plan. To register for the Fair PharmaCare Program, call 604 683-7175 from Vancouver or toll-free 1-800-663-7100 from the rest of BC. If you prefer to go online to the Fair PharmaCare website, the address is **https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan/register-for-fair-pharmacare**

   For Members who are self-paying their benefits, please refer to the Self-Payment section of this booklet for

information regarding the continued use of the drug card benefit.

2) Charges in excess of the amount payable under the Insured Person's Basic Medical Plan for professional licensed ambulance service in an emergency including transportation by railroad, boat or airplane, or in acute emergency by air ambulance, from the place where the injury or sickness occurs to the nearest acute general hospital and return fare, including round trip fare for one attending person (doctor, nurse, first aid attendant), where necessary. Transportation arranged after waiting for hospital accommodation for a condition not requiring immediate attention or transportation arranged at the patient's convenience are not eligible expenses.

3) Charges for out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. The maximum for these services will be limited to $25,000 per person during any 3 consecutive benefit years.

4) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, licensed dietician, osteopath (including x-rays), speech therapist, acupuncturist, registered psychologist, registered clinical counsellor, licensed social worker, podiatrist (including x-rays), chiropractor (including x-rays), naturopath (including x-rays), or physiotherapist, who is registered and legally practicing within the scope of their license. These charges will be covered at 100% up to a maximum of $1,500 per insured person per calendar year, for all eligible paramedical practitioner types combined.

5) Charges for oxygen, blood or blood plasma, ostomy or ileostomy supplies.

6) Charges for walkers, canes and cane tips, crutches, splints, casts, collars and trusses but not elastic or foam supports.

7) Charges for testing supplies, needles and syringes for diabetics.

8) Charges for surgical stockings to a maximum of 2 pair per calendar year.

9) Charges for stump socks.

10) Charges for surgical brassieres up to two per calendar year.

11) One pair of custom fitted orthopedic shoes when prescribed by a physician or podiatrist and replacements when necessitated by normal wear and tear.

12) One pair of custom made orthotics (including molds and arch supports) when prescribed by a physician or podiatrist to a maximum of $200 per calendar year.

13) Charges for rigid support braces and permanent prosthesis (artificial eyes, limbs, larynxes and mastectomy forms). Myoelectrical limbs are excluded but the Plan will pay the equivalent of a standard prosthesis.

14) Cost of rental or where more economical, purchase of durable equipment for therapeutic treatment including wheelchairs and hospital beds. Electric wheelchairs are covered only when a doctor certifies the patient is incapable of operating a manual wheelchair (e.g. Paraplegic).

15) Charges made by a dentist for the repair or replacement of sound, vital, natural teeth or the setting of a fractured or dislocated jaw if:

- those services are required as a result of a direct accidental blow to the month and not as a result of an object placed in the mouth;
- the accident occurred while the person is covered under this benefit; and
- the charges are incurred within 6 months of the date of the accident, unless the Plan approves a detailed treatment plan received from the Dentist within that 6 month period.

16) Hospital charges made by an approved acute general hospital in B.C. for private or semi-private room if ward is not available or if required as medically necessary by a physician (not including rental of telephone, T.V. etc.).

17) 50% of the cost of purchase and fitting of hearing aids for all eligible Members and their eligible dependents, up to a maximum of $2,500 in a five-year period provided that, wherever possible, WorkSafe BC is the first payer on behalf of Members.

18) Wigs and hairpieces required as a result of chemo-therapy up to a maximum of $300 per benefit year.

19) You can use your pay-direct card when you visit a licensed optometrist or ophthalmologist for an eye examination, up to a maximum of $85 every 24 months.

20) Convalescent Hospital to a maximum of $20 per day for a maximum of 180 days for treatment of an illness due to the same or related causes.

21) Laser eye surgery for all eligible Members and their eligible dependents, up to a lifetime maximum of $1,000.

EXCLUSIONS and LIMITATIONS:

The Plan's Extended Health Benefits does not cover:

a) expenses for benefits, care or services that result from a motor vehicle accident incurred on or after November 9, 2018, or which are payable by or under the Basic Medical Program, PharmaCare, any Hospital Program or the Workers Compensation Act, whether or not a claim is made thereunder or provided without cost or at a nominal cost by any public or tax-supported authority or agency or for which the Member or dependent can recover from a third party.

b) expenses for dental services except as specifically provided in Item 15.

c) any amount of fees in excess of the usual or recognized fees for the service performed.

d) expenses incurred outside the province of residence unless resulting from an unexpected injury or sickness occurring while temporarily travelling outside the province and then only to the extent provided under the section Out of Province/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein.

e) expenses of services and supplies for cosmetic purposes.

f) expenses caused, contributed to or necessitated as a result of:

- war or any act of war or participation in a riot or civil insurrection;
- injury or sickness which was intentionally self-inflected, whether sustained or suffered while sane or insane;
- occupational illness or injury; or
- the commission by the person of any unlawful act including an offense under the Criminal Code of Canada.

g) expenses incurred for orthoptic treatment, eyeglasses, contact lenses, hearing aids, or prescriptions for any of them except as specifically provided; (see Vision Care Plan).

h) any expenses that a covered person may obtain as a benefit under any government plan or law.

i) any payment to a medical practitioner whether or not a participant in the Basic Medical Plan in which is demanded or received by means of balanced billing, extra billing or extra charging which represents an

amount in excess of the schedule of costs prescribed by the Medical Services Plan.

j) Medical Marijuana, in any and all of its forms, regardless of whether or not having been prescribed by an attending physician.

MEDICAL REFERRAL BENEFIT

The Medical Referral Benefit provides coverage for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the insured person's government health insurance plan, Health Insurance Plan or EHC plan, for the insured person and an approved escort, up to a lifetime maximum of $75,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and

b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and

c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health Insurance Plan outlining their liability is required); and

e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and

f) the treatment must not be experimental or investigative in nature; and

g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and

h) the medical referral must be pre-approved, following submission of a request for pre-approval in writing to Global Excel, along with supporting documentation.

OUT OF PROVINCE/CANADA EMERGENCY MEDICAL TRAVEL INSURANCE

Emergency Medical Travel Insurance provides coverage for eligible Members and their eligible dependents for certain expenses incurred as a result of an emergency while

travelling outside your province. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Coverage Period: 180 days per trip

Policy Number: DAT00013344

Out of Province/Canada Emergency Medical Travel Insurance has a maximum of $5 Million per coverage period. The maximum age for coverage is upon reaching age 80.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible. If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and
- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered (for more details refer to the full Emergency Medical Travel Insurance Booklet. Ask for a copy from the Plan Administrator.)

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance. Global Excel can direct you to a

medical facility or doctor in your area of travel. If you contact Global Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date. In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment.

Coverage is for an unlimited number of trips up to the coverage period for each trip (180 days per trip); however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

CLAIMS PROCEDURES – EMERGENCY OUT OF PROVINCE/CANADA ELIGIBLE EXPENSES

You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim:

If in Canada or the United States,
call toll free at: 1-833-685-2790

From anywhere else in the world,
call collect to: + 519-735-9448

During your call, you will be given all the information required to file a claim.

You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non-payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used.
- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.
- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of reparation, date, quantity and total cost.
- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.
- Any other additional documents pertinent to your claim, as may be required by Global Excel.

Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

All sums under this Plan are in Canadian currency unless otherwise indicated. If you paid a covered expense in a currency other than Canadian currency, you will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Any information not provided may result in a delay in processing your claim.

All pertinent documents should be sent to:

Global Excel®

Global Excel Management Inc.
73 Queen St.
Sherbrooke, Quebec J1M 0C9

Policy Number: DAT00013344

Online Claim Submission:

Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format,such as a PDF or a JPEG.

VISION CARE
(eyeglasses/contact lenses)

The Vision Care Plan will cover you and your eligible dependents.
You must be prepared to prove that persons claimed as dependents are actually dependent upon you.

Covered Expenses
You can use your pay-direct card for the purchase of the following eligible expenses:

a) one set of single vision, bifocal or trifocal lenses, prescribed by a person legally qualified to make such a prescription;

b) one set of frames required when glasses are first prescribed or required to accommodate new lenses if existing frames are not serviceable.

c) contact lenses prescribed by a person legally qualified to make such a prescription.

Payment of Expenses
The maximum amount payable for an eligible Member or for an eligible dependent (regardless of consecutive months of coverage) shall be 100% of the actual expenses incurred or $750.00, whichever is the lesser, during any period of 24 consecutive months (12 consecutive months for dependent children under age 19).

EXCLUSIONS and LIMITATIONS
The cost of the following items are excluded from this Plan:

a) duplicate or spare eye glasses or any lenses or frames thereof;

b) safety goggles, sun glasses (plain or prescription);

c) replacement or lost, stolen or broken lenses or frames.

EMPLOYEE & FAMILY ASSISTANCE PROGRAM (EFAP)

The EFAP is a voluntary, confidential, short-term counseling and advisory service that connects you and your eligible family members to a network of dedicated professionals who are available to give you assistance 24 hours a day.

This benefit provides professional assistance for a wide range of issues such as:

- Personal and work-related stress;
- Couple and marital relationships;
- Childcare and parenting issues

- Family matters;
- Eldercare concerns;
- Depression and anxiety;
- Alcohol and drug abuse;
- Legal matters and financial concerns.

For additional information, please refer to the brochure available from the Administrator. Access the Employee and Family Assistance Program (EFAP) 24/7 by phone, web or mobile app.

Visit: **one.telushealth.com**

login username: **boilermakers191**
password: **eap**

or call **1-844-880-9137**

TO MAKE A CLAIM

Extended Health Benefits, Vision Care and Dental Plan: Use your benefit card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for dental visits and vision care purchases. If you do not use your benefit card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the members.coughlin.ca portal or mobile app (see page 33 for details).

Alternatively, you can complete the claim form for Extended Health/Vision benefits or Dental benefits; which can be completed and printed from the Plan's website: **www.boilermakers191benefits.org** or obtained from the Plan Administration Office. Your fully completed claim form and receipts can be **emailed to questions@boilermakers191benefits.ca** or **faxed to 905-946-2535** or mailed to:

Boilermakers Lodge No. 191 Benefit Office
45 McIntosh Drive
Markham, ON L3R 8C7

All claims must be received by the Administrator within 12 months of the date of service to be considered for payment.

COORDINATION OF BENEFITS:

1) When coordinating benefit payments, the Plan will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible expense was incurred.
2) If the Member or Dependent is also covered under the Spouse's plan or under any other group plan which provides similar benefits, payment will be coordinated

and/or reduced to the extent that benefits payable from all plans will not exceed 100% of the Eligible Expense (for dental, the fee guide applies).

3) The plan that determines benefits first (primary carrier) will calculate its benefits as though duplication of coverage does not exist.

4) The plan that determines benefits second (secondary carrier) limits its benefits to the lesser of:

   a) the amount that would have been payable had it been the primary carrier, or

   b) 100% of all Eligible expenses reduced by all other benefits payable for the same expenses by the primary carrier.

5) If the other plan does not contain a co-ordination of benefits clause, payment under that plan must be made before the Plan will pay under this provision.

6) Extended health care plans with dental accident coverage determine benefits before dental plans.

7) If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amounts that would have been paid had there been coverage by just that plan.

8) When the Plan has paid benefits to the Member to the limit of the Fair PharmaCare deductible, the Plan will pay their portion of the Eligible expenses based on the Plan's reimbursement percentage.

9) The Member will provide the information required to implement this provision. It is the Member's responsibility to present a copy of the original claim form and the remittance statement or cheque stub when making further claim under this provision.

When submitting eligible claims, please be sure to include:

- Your Name (please print)
- Your Address
- Your Certificate Number/Client ID
- Your Local Union

ONLINE AND MOBILE CLAIMS PAYMENT

Go to: members.coughlin.ca and look for the "Register" button. Click on the link. Complete all the required fields.

Your Group Number is 63038. Your Certificate number is found on your benefit card.

You can download the free Coughlin app by visiting the App Store for IOS devices or Google Play for Android devices. Search "Coughlin". Once downloaded, you can register or sign in to your account.

DIRECT DEPOSIT

If you have not already done so, you can sign up for Direct Deposit for your claims reimbursements. Get your reimbursement faster and have the funds deposited directly into your bank account rather than waiting for a physical cheque. On the members.coughlin.ca website or the Coughlin app, click on the Person icon on the top navigation. Go to Update Direct Deposit and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly).

Benefits Provided by:

Sun Life Financial Canada #G56709

Life Insurance
Spousal Life Insurance

The Boilermakers Lodge No. 191 Benefit Plan #56709

Weekly Indemnity
Extended Health Care
Vision
Dental

Manulife Group Travel Insurance #DAT00013344

Global Excel Management Inc.
Out of Province/Canada Emergency
Medical Travel Insurance

Medical Services Plan of BC #3131919

Basic Medical Coverage

TELUS Health #1004465

Employee & Family Assistance Program

This booklet explains in general terms the Plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policies issued to the Trustees.